

**IOWA MEDICAID MANAGED CARE
QUALITY ASSURANCE SYSTEM
For the Iowa Plan for Behavioral Health**

Department of Human Services

Bureau of Managed Care & Clinical Services

INTRODUCTION

As Quality Assurance and Improvement processes evolve nationally, this document is an attempt to summarize the existing strategies that have been or are being implemented in Iowa's Medicaid Managed Care program and to explore possibilities of utilizing clinical outcome-based research in the development of a set of measures to complement existing systems.

Nationally accepted standards like HEDIS 3.0 (and abridged versions) have been used as primary sources for included measures. Modifications were made as necessary to make these measures more applicable to behavioral health care delivery.

The National Academy of Sciences defines quality of health care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. Consequently, in the narrowest of terms, issues such as access to care, utilization/providing of medically necessary services and coordination and continuity of care would jointly constitute quality. When thinking of quality of health care in the managed care arena, it would be unwise to lose sight of purely structural issues (e.g., internal organization of the MCO, physician incentive plans, financial solvency, etc.) as those very readily translate into increased or decreased quality of “pure” health services.

As stated in the “A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States”, it is the providers of care (e.g., physicians and other practitioners) that are primarily able to affect quality of health care. However, under managed care, providers do not operate independently of assistance and/or restraints from MCOs with which they contract.

In light of the above, when Medicaid purchases care from MCOs rather than providers, it needs to exercise the opportunity to hold MCOs accountable for the quality of health services. As health care of high quality is (typically) cost-offsetting, all players should have an interest in improving the health status of managed care enrollees.

By contract, the managed care entity should be held responsible for addressing quality of care related problems at both the programmatic and individual provider level.

Managed Care History In Iowa

In Iowa, Medicaid Medical Managed Care programs serve close to 140,000 eligible clients from the Temporary Assistance to Needy Families and related eligibility categories (TANF and related).

Members are served through a state plan service:

Health Maintenance Organizations (also called MCOs)

MediPASS (Primary Care Case Management)

(Rural Health Clinics and Federally Qualified Health Centers may enroll as MediPASS providers)

MCEs (Managed Care Entities) describe either an MCO or a MediPASS patient manager.

Medicaid Managed Care in Iowa started as a pilot project with one MCO contract in one county in December of 1986. In 1990 Iowa implemented a pilot PCCM program called MediPASS in seven counties. Since then the program, no longer a pilot, has expanded to 93 counties for MediPASS and 43 counties for MCOs. Iowa currently contracts with one MCO for TANF and TANF-related populations for medical/surgical services only. Coverage of services remains unmodified for MediPASS and MCO services. Enrollment and payment are handled by the Iowa Medicaid Enterprise while another division within the Department of Human Services retains the determination of eligibility for Medicaid and determination of aid type categories that would require managed care program enrollment.

The MediPASS program is designed as a gate-keeper model with assignment of enrollees to contracted providers (patient managers). MediPASS patient managers receive a monthly administrative fee for each enrollee served. All other services are reimbursed through the fee-for-service (FFS) system. All managed care organization (MCO) contracts are with risk based entities

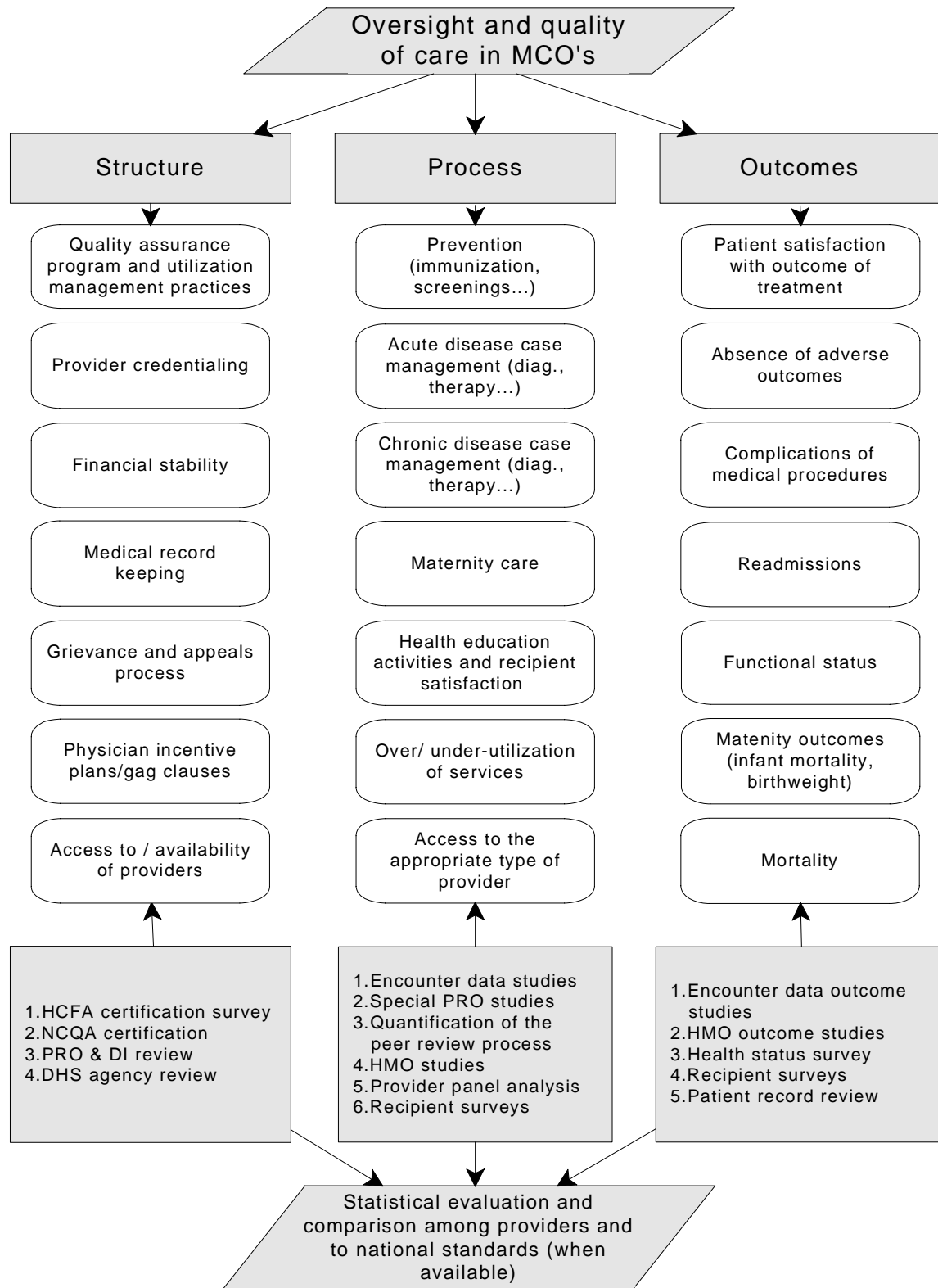
which are paid a capitation fee calculated on the basis of the last FFS experience for a given population, adjusted for age, sex and residence in state (i.e., six regions).

Mental health and substance abuse services are delivered to members (TANF and SSI) through a single statewide managed care contract.

Iowa Plan History

Mental health and substance abuse services are delivered to Iowa Medicaid recipients (FIP and SSI) through a single statewide managed care contract, The Iowa Plan for Behavioral Health. In 1995, the State implemented two separate behavioral health managed care programs, the Mental Health Access Plan (MHAP), implemented in March of 1995, and the Iowa Managed Substance Abuse Care Plan (IMSACP), implemented in September 1995. MHAP and IMSACP were merged into the Iowa Plan for Behavioral Health (Iowa Plan), effective January 1, 1999. In addition to managing Medicaid-funded mental health under the authority of the Iowa Department of Human Services (the Department), the Iowa Plan melds the efforts of the Department and the Iowa Department of Public Health (IDPH) for the provision of substance abuse services. Historically, certain substance abuse services were provided to Medicaid enrollees through primarily hospital-affiliated providers and to eligible uninsured Iowans through IDPH federal block grant and state appropriations, primarily by community-based providers. However, to achieve a full continuum of care and to address issues such as dual diagnoses, service coordination, and appropriate use of funding streams, a single point of coordination and consolidation of care has been developed through the provision of both mental health services and substance abuse treatment through the Iowa Plan and its single, state-wide contractor.

Figure 1: Medicaid Strategies for Quality Assurance in Contracted MCOs



Organizational Structure of Contracted MCOs

For the purpose of structural review, components of MCO operations (see Figure 1) are reviewed through on-site evaluations by the Department, the IME's contracted medical services unit and an independent reviewer responsible for writing a final report to CMS consistent with requirements of 42 CFR 438. Additional information regarding the MCO's financial stability is gathered through the Department of Insurance. Plans are required to submit copies of the National Association of Insurance Commissioner's reports to the Department on a quarterly basis. National Committee on Quality Assurance (NCQA) certification data, if available, may also be used for tracking purposes. Effective July 1, 2002, the Department required that all MCOs be accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the NCQA.

Organizational Background of the Iowa Plan

The Iowa Plan is a state-wide managed behavioral health care plan which integrates management of Medicaid mental health services and substance abuse treatment under a 1915b waiver through the Centers for Medicare and Medicaid Services. The waiver covers traditional Medicaid mental health and substance abuse services plus an expanded array of community-based services and supports. The waiver covers most of Iowa's Medicaid recipients except for: those over 65; those living in certain residential settings; those categorized as medically needy with a cash spenddown; and those with limited Medicaid benefits. The Iowa Plan contractor is fully capitated and at full risk for the development and delivery of Medicaid mental health and substance abuse services for Medicaid enrollees.

The Iowa Plan provider network is an open panel. Any qualified provider who is willing and able to meet the terms of subcontracting with the Iowa Plan contractor may contract to provide services regardless of whether that specific provider is able to enroll independently into the Medicaid program as a provider. Once contracted with the Iowa Plan contractor, each provider agrees to provide services in accordance with contract provisions. Iowa Plan provider subcontracts must be approved in format and in content by the Iowa Department of Human Services.

The Iowa Plan contractor is required by contract to develop and maintain a comprehensive quality improvement program that includes the following requirements: attain and maintain accreditation through a national body; evaluate the performance of clinical, preventative, and support processes; pursue opportunities to improve programs and outcomes; track public input through quality assurance processes; implement focused quality improvement studies and prevention programs; conduct satisfaction surveys; and monitor and report performance indicators established in the contract.

Quality Assurance Program and Utilization Management Practices

Quality Assurance Program

Development and Input

Process for Quality Strategy Development, Review, and Revision

Through established committees and roundtables, the Department and the Contractor seek input from sources that include governmental agencies, providers, consumers, family members and advocates to determine the focus of quality improvement activities and performance indicators.

Based on this input, annual quality improvement goals are drafted for approval by the Department and IDPH and for review by the Iowa Plan Advisory Committee, the State's advisory body for the Iowa Plan. The Advisory Committee is specifically comprised of Iowa Plan stakeholders who include consumers, family members, advocates, and providers as well as representatives from the State of Iowa's Departments of Corrections, Education, Human Services, and Public Health. Revisions to the proposed quality improvement goals reflect input by the Iowa Plan Advisory Committee that is approved by the Department and IDPH.

The quality improvement goals are part of the larger Iowa Plan Quality Plan, which also includes the Department's performance indicators for the Contractor.

The Quality Plan is reviewed by the Department on a monthly basis through the Iowa Plan Quality Improvement Committee. In addition, the Contractor submits a Quarterly Report to the Department that reports plan data and trends and an Annual Report that summarizes activities and data for the contract period. The Quarterly Report and the Annual Report are also submitted to the Quality

Improvement Committee and the Clinical and Community Advisory Committee (an advisory group to the Contractor) and are available to the Iowa Plan Advisory Committee.

The State will work collaboratively with the Contractor to develop and implement an effective Quality Assessment and Improvement (QA & I) program. The Contractor will be afforded the opportunity to offer feedback on QA & I expectations outlined by the State prior to the public comment process in order to achieve consensus on goals and expectations. Key Stakeholders, including the Contractor and beneficiaries, will have access to the QA & I Plan no less than 7 calendar days prior to the public meeting in order to review and comment before the document is finalized. Once finalized, the QA & I Plan will be reviewed annually by the State to assure effectiveness of measures and strategies. If significant changes to the document are required, the public comment process will be initiated. For purposes of this Plan, “significant changes” will be understood as a change to any standard within this document or the contract.

Additionally, the Quality Plan is published on the Department’s internet web page periodically and public input from any interested party, including members and any other stakeholder is actively sought.

Quality Plan Changes and Timelines

The Quality Plan is reviewed periodically by the Department and is an annual discussion topic for the Iowa Plan Advisory Groups. However, unless there is an immediate need to make changes, the plan is modified every two years through a process of re-review and appropriate additions. The plan incorporates the use of quality measures that are reviewed by the Iowa Plan Advisory Groups on an annual basis and the retrieval of such measures may be changed for the following year based on the recommendations of this group. Updates to the plan may reflect such decisions by this committee at the time the plan is formally reviewed and renewed.

Program Goals

The goals of the quality strategy are manifold. These include setting a structure whereby the Department may measure assess, monitor utilization each managed care plan to assure that there is

adequate access to necessary services and that services are being delivered appropriately to eligible and enrolled members. By developing standardized measures and continuing to monitor such standards, the Department can track improvement and assist the MCEs in the targeting of specific activities designed to increase positive outcomes for members.

MCO Contract Provisions

A. The MCOs will at a minimum, be in compliance with and seek to progressively improve outcomes compliant with, Federal and State statutes; the Quality Management Standard subparts D, E, and parts of subparts of F, I, J 438.200s and contracts and program requirements such as those listed below:

1. Availability of Services, including emergency and post stabilization of services;
2. Continuity and coordination of care;
3. Provider selection;
4. Enrollee information;
5. Enrollee rights;
6. Confidentiality and accuracy of enrollee information;
7. Enrollment and Disenrollment;
8. Subcontractual relationships and delegation;
9. Practice guidelines;
10. Health information systems;
11. Mechanisms to detect both under and over utilization of services;
12. Quality improvement;
13. Utilization management;
14. Member services;
15. Provider services;
16. Record keeping;
17. Access standards;
18. Data reporting.

B. The Quality Management Process of the MCO must include ongoing quality improvement

C. efforts that are implemented and maintained through internal processes that meet the following content requirements:

1. At the time of application into the Iowa Medicaid program, beneficiaries are given the opportunity to indicate their race, ethnicity and primary language. By federal law these are voluntary fields included in the application, but the information is collected when provided. This information is received from Iowa Automated Benefits Calculation System (IABC) and passed to the MMIS system. This information is collected into an 834 transaction field and is indicated in the race field and the primary language field, when applicable, and is then passed to the MCO electronically via the enrollment roster at the time of enrollment in the MCO.

D. An External Quality Review (EQR) of the MCO will be conducted annually related to quality outcomes, timeliness of and access to the services covered under each contract. External reviewers may utilize several methods to review this content including but not be limited to:

1. Licensure, Insurance, Other Legal Requirements
2. Credentialing of Providers
3. Confidentiality and Security
4. Medical records content/retention
5. Member education/Prevention programs
6. Provider payments
7. Cultural competency
8. Enrollment/Disenrollment timeliness
9. Grievances/Appeals
10. Coordination and continuation of care
11. Contract evaluation/MCO Monitoring Log/Encounter data
12. Quality Assurance Plan

E. The External Quality Review consists of the following reports:

1. Validation of two (2) performance improvement projects required by the State to comply

with requirements set forth in 42 CFR §438.240(b)(1), that were underway during the preceding 12 months. Some performance measures may be required by the state to be continued, based on specific outcomes for a specified period of time.

2. Validation of MCO performance measures reported (as required by the State) or MCO performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in 42 CFR §438.240(b)(2).
3. A review, conducted within the first year of this contract, and at least every 3 years thereafter, to determine the MCO's compliance with standards (except with respect to standards under 42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively) established by the State to comply with the requirements of 42 CFR §438.204(g).
4. Validate that the MCO has conducted the consumer and/or provider surveys as may be required by the Department. The EQR may evaluate and validate the methodology and results of the MCO survey(s). Cross-program, regional and national comparisons, as applicable, shall be made and the results reported to the Department as required.
5. Conduct a validation of encounter data reported by the MCO. The Department, at its discretion, may also require the EQRO to conduct a validation of encounter data reported by the MCO in succeeding years.
6. Conduct an assessment of the MCO's information systems. The Department, at its discretion, may also require the EQRO to conduct an assessment of the MCO's information systems in succeeding years.
7. The following activity may be required of the EQR during the contract term and shall be validated as complete:
 - a. Calculate and/or validate performance measures in addition to those reported by an MCO.
 - b. Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time.
 - c. Review of all additional performance improvement projects and ensure the use of the Performance Improvement protocol. A performance improvement project utilizing grievances and appeals as the topic may be conducted.

F. Intermediate Sanctions;

Sanctions may be imposed after confirmation of any of the following actions with determination based on onsite surveys, enrollee or other complaints, changes in financial status, or any other source.

1. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
2. Imposes on enrollees, premiums or charges in excess of permitted charges.
3. Acts to discriminate among enrollees on the basis of their health status or need for health care services.
4. Misrepresents or falsifies information that it furnishes to CMS or to the State.
5. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210
7. Has distributed directly, or indirectly through any agent or independent contractor, marketing material.
8. Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

G. Intermediate Sanctions that may be imposed:

1. Civil Monetary Sanctions,
2. Temporary Management: The State shall impose temporary management in the event it finds that the MCO has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Act. The MCO shall recognize the authority of temporary management appointed to oversee MCO. The State shall not delay imposition of temporary management to provide hearing prior to imposing this sanction. The State shall not terminate temporary management until such time that it determines that the MCO can ensure that the sanctioned behavior will not recur. In the event that the State shall impose temporary management, the

State shall also grant enrollees the right to terminate enrollment without cause and shall notify the affected enrollees of their right to terminate enrollment.

3. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction,
4. Termination: Termination of the Contract for failure to carry out the substantive terms of this contract or to meet applicable requirements in section 1932, 1903(m) and 1905(t) of the Act.

H. All services covered in the State Plan and the contract between the MCO and the Department are the responsibility of the MCO and must be available and accessible to their enrollees as listed below. These services may require a prior authorization from the MCO.

1. Ensure that emergency services, emergency post stabilization and family planning services are not restricted by referral,
2. Inpatient hospitalization,
3. Non psychiatric services,
4. Professional, clinic visits and other laboratory testing and radiology,
5. Outpatient hospital laboratory and radiology,
6. Outpatient hospital,
7. Home care,
8. Ambulance transportation,

I. All services provided must meet the criteria for access as listed below.

1. Procedures in place to provide coverage, either directly or through its primary care providers, to enrollees on a 24 hours per day, 7 days per week basis. The procedures shall include availability of 24 hours, 7 days per week access by telephone to a live voice (an employee of the MCO or an answering service) which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. The management of incoming calls from enrollees must be clearly defined including equal access to all participants.

2. Network providers including primary care physicians and hospitals should be located within a reasonable distance of where enrollees reside. If no primary care physician or hospital is located in a given county, the MCO shall ensure that services are provided to enrollees located within that county. The MCO may include providers from other states in their provider network. The MCO, in establishing and maintaining its network of providers must consider the geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
3. Network providers shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. The MCO shall establish procedures to ensure that network providers comply with all timely access requirements and be able to provide documentation demonstrating the monitoring of this element. Corrective actions must be defined and utilized if a provider is found to be noncompliant within the scope of these procedures.
4. Written policies and procedures describing how members and providers may contact the MCO to receive individual instruction on accessing emergency and post-stabilization care services or receiving prior-authorization for treatment of an urgent medical problem and instruction when outside the state defined geographic area.
5. Policies and procedures must be available in an accessible format upon request.
6. Direct contact with qualified clinical staff must be available through a toll-free voice and telecommunication device for the deaf telephone number.
7. The MCO shall notify enrollees, applicants or potential applicants of the right to receive any documents translated and/or oral interpretation services at no cost. Translation services available must include prevalent languages for the population to be served. Specific languages may be required as updated state census data becomes available.
8. Out-of-network providers shall be an option for the enrollee in the event a network provider is not available. Out-of-network providers must coordinate with the MCO with respect to payment. The Contractor must ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network.

9. Enrollees shall have access to Out-of-Network Providers when appropriate services are not available within the MCO network. Each MCO must require that if the network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO must adequately and timely cover these services out of network for as long as the MCO network is unable to provide them.
10. Each MCO shall require out-of-network providers to coordinate with the MCO with respect to payment. The MCO must ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network.
11. Each MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee.
12. Each MCO must ensure that its providers are credentialed and re-credentialed per NCQA guidelines as required in the regulation.
13. Each MCO must participate in the States efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
14. Each MCO contract must require that the entity submit documentation to the State to demonstrate in a format specified by the State, that it:
 - a. Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area.
 - b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
15. Each MCO contract must require that the entity submit documentation of adequate capacity and services as specified by the State, and specifically as follows but no less frequently than:
 - a. At the time it enters into a contract with the State.
 - b. At any time there has been a significant change (as defined by the State) in the entity's operations that would affect adequate capacity and services, including—changes in services, benefits, geographic service area or payments, or;

- c. Enrollment of a new population in the MCO.
 - d. All MCOs are required to have a Certificate of Authority from the office of the Insurance Commissioner prior to establishing operations in any county. After such certificate is granted, based on access and availability of providers, the Department also undertakes a review of availability. Holding such a Certificate does not automatically qualify the MCO to contract for services in any specific county with authority granted from the Department.
16. Each MCO contract must require that the entity implement procedures:
- a. To ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
 - b. To coordinate the services the MCO furnishes to the enrollee with the services the enrollee receives from any other MCO.
 - c. To share with other MCOs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated.
 - d. To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 164.
17. Each MCO contract must require that the entity implement procedures that:
- a. Ensure the provision of medically necessary services as specified, subject to all terms, conditions and definitions of the contract. Any and all disputes relating to the definition and presence of medical necessity shall be resolved as determined by the Department. Covered services shall be available through the MCO or its subcontractors. Experimental surgery and procedures are not covered under the State Title XIX Plan. MCOs may cover experimental surgery and procedures but shall not require members to undergo experimental surgery or procedures
 - b. Ensure that during the delivery of services that they may not be arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

- c. Place appropriate limits on a service based on criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
 - d. Provide medical services in such a manner as described by the State Plan as Medically Necessary Services.
 - e. Ensure that a process is in place to assess the quality and appropriateness of care furnished to enrollees and that enrollees have regular documentation of treatment plans and evaluation of those plans by team members. Where revision in a care plan appears to be necessary, the staff revises the treatment plan. Results are available to the State upon annual audit and at any other time the State requests such information.
19. Address the extent to which the MCO is responsible for covering Services related to:
- a. the prevention, diagnosis, and treatment of health impairments,
 - b. the ability to achieve age-appropriate growth and development,
 - c. the ability to attain, maintain, or regain functional capacity.
20. That the MCO and its subcontractors have in place, and follow, written policies and procedures for:
- a. processing requests for initial and continuing authorizations of services
 - b. that the MCO has in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.
 - c. that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
 - d. that the MCO notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.
21. Each contract must provide for the following decisions and notices:

- a. Standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee, or the provider, requests extension; or the entity justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- b. Expedited authorizations for cases in which a provider indicates that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
- c. The MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the entity justifies (to the State agency) a need for additional information and how the extension is in the enrollee's interest.
- d. Each contract must provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

J. The Health Care Delivery Network, in establishing and maintaining its network of providers must consider the following:

1. The anticipated Title XIX – Medicaid and Title XXI enrollment;
2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Title XIX – Medicaid and Title XXI populations represented in the MCO enrollment population;
3. The numbers and types (in terms of training, experience, and specialization) of providers required to provide the contracted services;
4. The numbers of network providers who are not accepting new Title XIX – Medicaid enrollees.

5. Providers who would provide care to those identified as individuals with special health care needs. Although Title V covered children who receive comprehensive services are not enrolled in medical managed care, any individual identified by the MCO through an initial screening or otherwise identified as having a special health care need- must have access to appropriate medically necessary services.

Measurement and Improvement Standards

A. Practice Guidelines:

The State must ensure through its contracts that each MCO adopts practice guidelines that meet the following requirements that will be reviewed at annual audit and at any other time that the State requests:

1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
2. Consider the needs of the enrollees;
3. Are adopted in consultation with contracting health care professionals,
4. Are reviewed and updated periodically as appropriate.

B. Dissemination of guidelines

1. Each MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
2. Application of guidelines
3. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines. These will be reviewed upon annual audit and at any other time that the State requests.
4. Quality assessment and performance improvement program.

C. Each MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

- D.** CMS, in consultation with the State and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by State in their contracts with MCOs.
- E.** Each MCO shall have in place mechanisms to detect both underutilization and over utilization of services. These will be reviewed annually and more frequently as requested by the State.
- F.** Each MCO shall have in place mechanisms to assess the quality and appropriateness of care furnished to all enrollees.
- G.** Performance measurement

Each MCO shall annually demonstrate documentation of the following performance measures:

1. Measure and report to the State its performance, using standard measures required by the State;
 2. Submit to the State, data specified by the State, that enables the State to measure the entity's performance; or
 3. Perform a combination of the activities listed above (i.e., measure and report to the State its performance and submit data specified by the State).
- H.** Performance improvement projects

Each MCO shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. All such projects must involve the following:

1. Measurement of performance using objective quality indicators.
2. Implementation of system interventions to achieve improvement in quality.
3. Evaluation of the effectiveness of the interventions.
4. Planning and initiation of activities for increasing or sustaining improvement.
5. Each contract must require that the entity report the status and results of each project to the State as requested.

6. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- I.** Quality Assessment and Performance Improvement Program review by the State.
The State shall annually review the impact and effectiveness of the MCO quality assessment and performance improvement programs. The review must include but is not limited to:
 1. Performance on the standard required measures.
 2. The results of each performance improvement project.
 - J.** Each MCO must maintain a Health Information System (HIS) that:
 1. Collects complete and accurate data on enrollees and providers regarding information and services furnished through encounter data,
 2. Ensures data is accurate and complete,
 3. Makes sure data is available to the State of Iowa and Centers for Medicaid and Medicare Services (CMS).

The integrity of the quality assurance programs in MCOs is crucial for success of any QI plan as they act as support for such efforts. MCOs are required to provide a description of the MCO's Quality Improvement program or plan for Quality Improvement to the Department. The quality assessment and performance improvement program must achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in projects concerning significant aspects of clinical care and non-clinical services that can be expected to affect enrollee health status, functional status, and satisfaction. It is crucial that noted improvement be related to the QI projects rather than be a random occurrence.

For the purpose of satisfying the requirement of clinical care focused projects, this QI program is required to pursue the improvement in areas of particular interest to the Department. Some of the obvious initial choices for this requirement are the amount and duration of behavioral health hospitalizations and follow up after hospitalizations . On a quarterly basis as requested by the

Department, the MCO provides a description of the QI program and plan which works toward evaluation/assessment for the purpose of improvement of the overall quality of MCO services and processes. These QI plans must have clearly identified potential reasons for sub-optimal performance, opportunities for improvement, proposed activities to be performed within the scope of the QI program, and timeline for such activities. The continuous evaluation, as well as modifications and reasons for them, of the QI program by QI committee needs to be demonstrated in the QI Committee activities' documentation. Additionally, the MCO is required to select two issues from the following 6 non-clinical focus areas:

- Complaints and Grievances
- Denials of authorization or payment for services
- Cultural competence
- Availability of desired service
- Convenience of available services
- Timeliness of available services

For the QI project(s) focusing on non-clinical issues MCOs are to follow the procedure outlined above for the clinical focus areas.

Structure of the MCO

MCOs are also required to;

Comply with applicable standards as set by the Department which includes that the MCO must have a quality improvement system which:

- (a) Is consistent with the utilization control requirements of 42 CFR 456;
- (b) Provides for review by appropriate health professionals of the process followed in providing health services;
- (c) Provides for systematic collection of data on system and provider performance and participant outcomes;
- (d) Provides for provision and interpretation of these data to the practitioners on a regular basis, not less often than annually; and
- (e) Provides for making needed changes to improve quality and evaluating their results.

- (f) Provides descriptive information on the operation, performance and success of its Quality Improvement system to the Department.
- (g) Maintains and operates a Quality Improvement program which includes at least the following elements:
 - 1. A quality improvement plan outlining strategies and timeframes for expected achievement of projected goals.
 - 2. A person who is responsible for the operation and success of the QI Program. This person shall have adequate experience for successful QI, and shall be accountable for QI in all the MCO's provider network, as well as with the MCO's subcontractors.
 - 3. The QI Director shall spend an adequate percentage of time on QI activities to ensure that a successful QI Program will exist. The QI program shall have access on an as-needed basis to a variety of health professions (e.g., pharmacy, ~~physical therapy~~, nursing, etc.), and shall be directed by a QI committee which includes representation from:
 - a variety of disciplines (e.g., medicine, child psychiatry, hospitals, substance abuse residential facilities etc.);
 - MCO Board of Directors.
 - 4. The QI committee shall be in an organizational location within the MCO such that it can be responsible for all aspects of the QI program.
 - 5. QI activities shall be sufficiently separate from Utilization Review activities, in personnel and organizational location so that QI activities can be distinctly identified as such.
 - 6. The QI activities of the MCO's provider network and subcontractors, if separate from MCO QI activities, shall be integrated into the overall MCO/QI program, and the MCO shall provide feedback to the provider network/subcontractors regarding the operation of such independent QI effort.
 - 7. The QI committee shall meet at least quarterly and produce written documentation of committee activities to be shared with the Department.

8. The results (i.e., success or failure) of the QI activities as revealed by selected indicators shall be reported in writing quarterly to the MCO Board of Directors and the Department.
9. The MCO shall have a written procedure for following up on the results of QI activities to determine success of implementation. Follow-up shall be documented in writing.
10. Where the Department determines that a QI plan does not meet the above requirements, the Department will provide the MCO with a model plan. The MCO agrees to modify its QI plan based on the model so that the MCO's QI plan meets the above requirements provided, that the MCO shall retain sole authority over the design and implementation of its QI plan, subject only to its obligation to comply with the above requirements. Failure to submit a plan within six months will result in contract termination.

Utilization Management Practices

MCOs are allowed to waive, to the extent allowed by law, any current Department requirements for prior authorization, copayment, or other Medicaid restrictions for the provision of contract services to enrollees. This, however, does not preclude the requirement of MCOs to provide all Medicaid covered services to members. This also poses additional review requirements on the Department to assure that utilization management practices are both in compliance with

the law

Medicaid covered services

definitions of medically necessary/appropriate services

the best medical practices

It is important that MCO UR staff be aware of the Medicaid coverage policies to prevent any inappropriate restrictions of services due to coverage issues.

The Department is monitoring the internal quality improvement program and utilization management practices through on-site reviews by the Department staff and contracted PRO staff. On site review is designed in accordance with federal regulation.

Practice Guidelines and New Technology

In cases where specific clinical practice guidelines are adopted by MCOs and enforced among the participating practitioners, the MCO must have an outline of the mechanism for the adoption of any such guidelines. Guidelines must be based on reasonable medical evidence or a consensus of relevant practitioners (e.g., guidelines promulgated by Agency for Health Care Policy and Research) and should be reviewed and updated periodically. Such guidelines are to be communicated to providers and, as necessary to enrollees through manuals, newsletters or other communications.

The MCO is also required to have a clear written policy and procedure for review and adoption of new and uses of existing technologies. Such determinations may not be more exclusive than coverage established by the Department. The information to be considered in any such determination must include scientific evidence, a review of findings by the Food and Drug Administration and other regulatory bodies as well as federal and state Medicaid coverage decisions, and consultation with affiliated practitioners and outside experts. Coverage determinations are communicated to providers of services.

Practice guidelines and technology review determinations are not to exclude any medically necessary services as defined by the Department.

Provider Credentialing Procedure

The MCOs are required to manage a credentialing, re-credentialing, recertification, or performance appraisal process for contracted providers which takes into consideration data which may include, but are not limited to: enrollee complaints, results of quality reviews, utilization management information, and enrollee satisfaction surveys. The MCO is required to verify qualifications of providers in accordance with all state licensing standards, all applicable accrediting standards, Medicaid/Medicare Sanction-Reinstatement Report, and any other standards established by the Department or Federal government to assure quality of services.

At a minimum, the following information must be verified from primary sources, or as otherwise required by the Department, and included in credentialing reports:

- a current valid license to practice;
- if applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- if applicable, a valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances certificate (CDS);
- education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, if applicable;
- board certification if the practitioner states that he/she is board certified on the application;
- current, adequate malpractice insurance meeting the HMO's requirements; and history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner. (This information can be obtained from the malpractice carrier or from the National Practitioner Data Bank.)
- information about sanctions or limitations on licensure from the applicable state licensing agency or board, or from a group such as the Federation of State Medical Boards;
- information on previous sanction activity by Medicare and Medicaid. (This may be obtained through the HHS Medicare and Medicaid Sanctions and Reinstatement Report or through direct contact with the DEPARTMENT or the Medicare intermediary.)

The Department, largely through on-site reviews, monitors the MCO credentialing process for quality.

For each provider or supplier, the MCO is required to determine and re-determine periodically that the provider or supplier is/was continuously licensed to operate in the state and in compliance with state or federal requirements. Additionally, the MCO must assure that these providers are certified as meeting the requirements of Medicaid, are reviewed and approved by an approved accrediting

body (e.g., JCAHO, AAAHC, etc.), if applicable, or are determined by the MCO to meet the standards established by the MCO itself.

The MCO is required to notify licensing and disciplinary bodies as well as the Department when a practitioner's or provider's affiliation is suspended or terminated because of quality deficiencies.

Contracted MCO Financial Stability Assessment and Tracking

MCOs are also monitored for their financial stability as severe financial difficulties might impact quality of services long before the crisis is manifest. The Department of Insurance is the primary body monitoring the MCOs' compliance with the law (IAC Chapter 40), particularly as it relates to reserve requirements. MCOs quarterly and annually submit National Association of Insurance Commissioners (NAIC) forms to both the Department and the Department of Insurance. Data from this form are abstracted internally to generate HEDIS 3.0 based MCO Financial Stability Profile

Following are the specific items being monitored:

- Medicaid payments to and Medicaid enrollment in the plan

- Membership

- Total (Commercial + Medicaid + Medicare) Membership

- Performance Measures

- Total Revenue

- Net Income

- Net Worth

- Debt-to-service coverage

- Overall loss ratio

- Administrative loss ratio

- Medical loss ratio

- Operating Profit Margin

- Liquidity Indicators

Days cash on hand
Ratio of cash to claims payable
Net Worth Percent Change
Net Worth Per Member
Efficiency Indicators
Days in receivables
Days in unpaid claims
Statutory Indicators
Admitted reserves
State minimum reserve requirements

Medical Record Keeping

MCOs are required to maintain a system of medical records which complies with Iowa Administrative Rules 441--88.69(2)(249A). MCOs must file a letter with the Commissioner of Insurance so as to be compliant with Iowa Code 228.7 regarding disclosure of mental health information.

The MCO must have in effect arrangements with its contracted providers that provides for an adequate medical record keeping system which includes a complete medical record for each enrolled member.

Following medical record standards have been adapted from “A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States” published by Centers for Medicare and Medicaid and are offered to MCOs as part of their contract in lieu of guidance on medical record standards.

Medical Record Standards

1. Complete Patient Record Standards. The record reflects all aspects of patient care, including ancillary services.

- patient identification information - Each page or electronic file in the record contains the patient's name or patient ID number.
- personal/biographical data - Personal/ biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.
- entry date - All entries are dated.
- provider identification - All entries are identified as to author.
- legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.
- allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies -- NKA) is noted in an easily recognizable location.
- past medical history - (for patients seen 3 or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history also includes prenatal care and birth events.
- immunizations - for pediatric records (ages 12 and under) there is a completed immunization record
- diagnostic information
- medication information
- identification of current problems - Significant illnesses, ongoing or chronic medical conditions and health maintenance concerns are identified in the medical record.
- smoking/ETOH/substance abuse - Notation concerning cigarettes and alcohol use and substance abuse is present. (For patients 12 years and over and seen 3 or more times.)
- abbreviations and symbols may be appropriate.
- consultations, referrals and specialist reports
- Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying

review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

- emergency care
- hospital discharge summaries - discharge summaries are included as part of the medical record for:
 - (1) all hospital admissions which occur while the patient is enrolled in the MCO and
 - (2) prior admissions as necessary.
- advance directive - For medical records of adults (21+), the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

2. Patient visit data - documentation of individual encounters must provide adequate evidence of, at a minimum:

- History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints.
- plan of treatment;
- diagnostic tests;
- therapies and other prescribed regimens;
- follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
- referrals and results thereof; and all other aspects of patient care, including ancillary services.

Medical Record Confidentiality

MCO contracted providers must maintain the confidentiality of medical record information and release the information only in the following manner:

- All medical records of enrolled members are confidential and are not to be released without the written consent of the covered persons or responsible party.
- Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities that are providing services to enrolled members under a subcontract with the MCO. This provision also allows release of information to specialist providers who are retained by the MCO to provide services which are infrequently used or are of an unusual nature. This also allows for transfer of information (written or verbal) to the Department managed care staff.
- Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 498--88.69(3)(249A), or to the MCO administrative staff.
- Written consent is required for the transmission of the medical record information of a former enrolled member to any physician not connected with the MCO.
- Written consent is not required for submission of immunization information to the State's immunization tracking system.
- The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.
- Compliance with the HIPAA regulations regarding security, confidentiality and electronic submissions of data.

Grievances and Appeals

Each MCO must have such a process in place for use by both recipients and providers of services. The Process will include a grievance system as defined below. The Grievance Procedure guidelines are outlined in Article IX of the contract between the Department and the MCO. The State delegates to the MCO responsibility for notice of action under Subpart E of 42 CFR part 431. The State will conduct random reviews of each MCO and its providers and subcontractors to ensure that they are notifying enrollees of their State Fair Hearing rights in a timely manner.

Quarterly Grievance and Appeal Report

On a quarterly basis, the Health Plan shall submit to the State agency a Quarterly Grievance, and Appeal Report summarizing each grievance and appeal handled during the quarter and a quarterly report summarizing all grievances and appeals. All MCOs and the Fiscal Agent staff will be required to utilize the standard format to report grievances and appeals. An additional requirement is that in all cases where the Department needs additional information, all pertinent documentation, including patient records, will be provided to the Department

The Health Plan shall have a system in place for Enrollees and Providers acting upon their behalf which includes a grievance process, an appeal process, and access to the State agency's fair hearing system.

GRIEVANCE SYSTEM

Member Grievance System:

The Health Plan shall have a system in place for Enrollees and Providers acting upon their behalf which includes a grievance process, an appeal process, and access to the state agency's fair hearing system.

Definitions

For purposes of the Health Plan's grievance/appeal process, the following definitions and requirements shall apply:

Action - Can Mean Any of the Following:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;

- Failure of an MCO to act within the timeframes.

Appeal – A request for review of an action, as action is defined in this section.

Appeal Process - The Health Plan's process for handling of appeals that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file an appeal, the process for resolution of an appeal, the right to access the Fair hearing system, and the timing and manner of required notifications.

Grievance - An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the member's rights.

Grievance Process - The Health Plan's process for handling of grievances that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file a grievance, the process for disposition of a grievance, and the timing and manner of required notifications.

Grievance System – The overall system in place for members that includes a grievance process, an appeal process, and access to the Fair hearing system.

Inquiry - A request from a member for information that would clarify Health Plan policy, benefits, procedures, or any aspect of Health Plan function but does not express dissatisfaction.

Service Authorization and Notice of Action

Denial Procedure Requirement - Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a

health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

Provider Notice of Adverse Action - The MCO must notify the requesting Provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. This notice to the Provider does not need to be in writing.

Enrollee Notice of Adverse Action – The MCO must notify the Enrollee in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested or agreed upon, or any action, as “action is defined in this section, except for denial of payment. Notice is not required to the enrollee when an action is due to the provider's failure to adhere to contractual requirements and there is no adverse action against the enrollee. The MCO must give the Enrollee written notice of any action (not just service authorization actions) within the timeframes for each type of action.

Content - The notice must explain:

- The action the MCO or its Subcontractor has taken or intends to take;
- The reasons for the action;
- The Enrollee's or the Provider's right to file an appeal;
- If the State does not require the Enrollee to exhaust the MCO level appeal procedures, the Enrollee's right to request a Fair hearing;
- Procedures for exercising Enrollee's rights to appeal or grieve;
- Circumstances under which expedited resolution is available and how to request it;
- The Enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services.

Language and format - The notice must be in writing and must meet the language and format requirements as follows:

Language -

- The state must establish a methodology for identifying the prevalent, a significant number or percentage, of non-English languages spoken by Enrollees and potential Enrollees throughout the State;
- The state must make available written information in each prevalent non-English language;
- The MCO must make its written information available in the prevalent non-English languages in its particular service area;
- The MCO must make oral interpretation services available for all languages free of charge; and
- The MCO must notify Enrollees and potential Enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

Format - Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Enrollees and potential Enrollees must be informed that information is available in alternative formats and how to access those formats.

Timeframes for Notice of Action

Termination, suspension or reduction of services

The MCO must give notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-Covered Services, except:

- the period of advanced notice is shortened to 5 days if probable recipient fraud has been verified
- By the date of the action for the following:
 1. in the death of a recipient;

2. a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
3. the recipient's admission to an institution where he is ineligible for further services;
4. the recipient's address is unknown and mail directed to him has no forwarding address;
5. the recipient has been accepted for Medicaid services by another local jurisdiction;
6. the recipient's physician prescribes the change in the level of medical care;
7. an adverse determination made with regard to the preadmission screening requirements
8. or Nursing Facility admissions on or after January 1, 1989; or
9. the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for Nursing Facility transfers).

Denial of payment – The MCO must give notice on the date of action when the action is a denial of payment. Notice is not required to the enrollee when an action is due to the provider's failure to adhere to contractual requirements and there is no adverse action against the enrollee.

Standard Service Authorization denial – The MCO must give notice as expeditiously as the Enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the Enrollee, or the Provider, requests extension; or the MCO justifies a need for additional information and how the extension is in the Enrollee's interest (upon State request).

If the MCO extends the timeframe, the MCO must give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or

she disagrees with that decision; and issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

Expedited Service Authorization denial – For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires to the Provider and recipient as may be required and no later than 3 working days after receipt of the request for service.

Extension - The MCO may extend the 3 working days time period by up to 14 calendar days if the Enrollee requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Enrollee's interest (upon State request).

Untimely Service Authorization Decisions – The MCO must give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

Grievance Process General Requirements

The MCO must:

- Give Enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. This includes providing a full and complete explanation of the process to the Enrollee
- Acknowledge receipt of each grievance.
- Ensure that decision makers on grievances were not involved in any previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:
 1. a denial of service was based on lack of medical necessity.

2. a grievance regarding denial of expedited resolutions of an appeal.
3. any grievance involving clinical issues.
4. Inform the Enrollee of the disposition of the grievance in a format approved by the State agency.
5. Inform the Enrollee of the availability of the MCO appeal process and the state fair hearing process.

Grievance System: Record keeping and reporting

The MCO must maintain records of grievances and appeals. Such records will be made available to the state agency upon request. A log of all grievance and appeals shall be delivered to the state agency as required under Article VII of this Contract.

Appeal Process: General Requirements

Authority to file - an Enrollee may file an MCO level appeal. A Provider, acting on behalf of the Enrollee and with the Enrollee's written consent, may file an appeal.

Timing - The Enrollee or Provider may file an appeal within a reasonable timeframe that cannot be less than 20 days and not to exceed 30-days from the date on the notice of action.

Procedures - The Enrollee or Provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal.

The MCO must:

- ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Enrollee or the Provider requests expedited resolution;
- provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

- allow the Enrollee and representative opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records;
- consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the appeal.

Resolution and Notification

The MCO must resolve each appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within State-established timeframes not to exceed 45 days from the day the MCO receives the appeal.

Format and Content of Resolution Notice

The MCO must provide written notice of disposition. The written resolution notice must include:

- The results and date of the appeal resolution.
- For decisions not wholly in the Enrollee's favor:
- The right to request a Fair hearing,
- How to request a Fair hearing,
- The right to continue to receive benefits pending a hearing,
- How to request the continuation of benefits, and
- If the MCO's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits

Continuation of benefits

The MCO must Continue the Enrollee's benefits if:

- The appeal is filed timely, meaning on or before the later of the following:
- Within 10 days of the MCO mailing the notice of action.

- the intended effective date of the MCO's proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The authorization period has not expired; and
- The Enrollee requests extension of benefits.

Duration of continued or reinstated benefits

If the MCO continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- The Enrollee withdraws the appeal.
- The Enrollee does not request a fair hearing within 10 days from when he MCO mails an adverse MCO decision.
- A Fair hearing decision adverse to the Enrollee is made.
- The authorization expires or authorization service limits are met.

Enrollee responsibility for services furnished while the appeal is pending

The MCO may recover the cost of the continuation of services furnished to the Enrollee while the appeal was pending if the final resolution of the appeal upholds the MCO's action.

Effectuation when services were not furnished

The MCO must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the appeal is pending and the MCO or the fair hearing officer reverses a decision to deny, limit, or delay services.

Effectuation when services were furnished

The MCO the State must pay for disputed services, in accordance with State policy and regulations, if the MCO or the Fair hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending.

Expedited Appeal Process

General

The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the Enrollee) or the Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

Authority to File

The Enrollee or Provider may file an expedited appeal either orally or writing. No additional Enrollee follow-up is required.

Resolution and notification

The MCO must resolve each expedited appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within State-established timeframes not to exceed 3 working days after the MCO receives the appeal.

Requirements following extension

For any extension not requested by the Enrollee, the MCO must give the Enrollee written notice of the reason for the delay.

Format of resolution notice

In addition to written notice, the MCO must also make reasonable efforts to provide oral notice.

Punitive action

The MCO must ensure that punitive action is not taken against a Provider who either requests an expedited resolution or supports an Enrollee's appeal.

Action following denial of a request for expedited resolution

If the MCO denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the standard timeframe of no longer than 45 days from the day the MCO receives the appeal with a possible 14-day extension (see 438.408(b)(2); and
- Give the Enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two calendar days.

Access to State Fair Hearing

Fair hearing Process: MCO notification of State Procedures.

If the MCO takes action and the Enrollee requests a State Fair hearing, the State (not the MCO) must grant the Enrollee a Fair hearing if such a request is made within the policies established by

the Department of Human Services. The right to a fair hearing and how to obtain a hearing must be explained to the Enrollee and Provider by the MCO. Other information for Enrollees and Providers would include:

- An Enrollee may request a State Fair hearing. The Provider may request a State Fair hearing only if the State permits the Provider to act as the Enrollee's authorized representative.
- The State must permit the Enrollee to request a State Fair hearing within a reasonable time period specified by the State as within 30 days from the MCO's final decision.
- The State must reach its decisions within the specified timeframes:
 1. Standard resolution: within ninety (90) days of the date the Enrollee filed the appeal with the MCO if the Enrollee filed initially with the MCO (excluding the days the Enrollee took to subsequently file for a Fair hearing) or the date the Enrollee filed for direct access to a Fair hearing.
 2. Expedited resolution (if the appeal was heard first through the MCO appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that:
 3. Meets the criteria for an expedited appeal process but was not resolved using the MCO's expedited appeal timeframes, or
 4. Was resolved wholly or partially adversely to the Enrollee using the MCO's expedited appeal timeframes.
 5. Expedited resolution (if the appeal was made directly to the Fair hearing process without accessing the MCO appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

Fair hearing: Parties - The parties to the State Fair hearing include the MCO as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

The Health Plan shall develop and implement written policies and procedures that detail the operation of the grievance system and provides simplified instructions on how to file a grievance or appeal and how to request a fair hearing.

Record Keeping and Reporting Requirements:

The Health Plan shall log and track all inquiries, grievances, and appeals.

The Health Plan shall maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of grievance, date of decision, and the disposition. If the Health Plan does not have a separate log for MHC managed care members, the log shall distinguish MHC managed care members from other Health plan Enrollees.

The Health Plan shall maintain records of appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. If the Health Plan does not have a separate log for MHC managed care members, the log shall distinguish MHC managed care members from other Health plan Enrollees.

The Health Plan must report grievances and appeals to the state agency in the format and frequency specified by the state agency. The state agency shall provide the Health Plan with no less than ninety (90) days notice of any change in the format or frequency requested.

The state agency may publicly disclose summary information regarding the nature of grievances and appeals and related dispositions or resolutions in consumer information materials.

Physician Incentive Arrangements

Many MCOs, in signing contracts with providers, put in place incentive arrangements to curb unreasonable referral patterns and utilization of other services not performed by the primary care

physician. Federal regulation has indicated a margin of 25 % as an upper percentage of physicians potential income that may be placed at risk by an MCO without significant consequences. If such risk exceeds 25% physicians are significantly disincentivized from providing necessary referrals and performing reasonable laboratory tests. The quality of services in such MCOs is very likely to suffer as a consequence of such arrangement.

Federal regulations further prescribe that MCOs that place physicians at a significant financial risk have to conduct Consumer Assessment of Health Plans Survey (CAHPS) (i.e., member satisfaction survey) to demonstrate that quality of services did not suffer. Additionally, these MCOs have to provide the contracted physicians with stop-loss insurance the amount of which is determined based on the number of MCO enrollees for which the physician is bound by the incentive agreement as the primary care provider.

The Department annually reviews contracted MCOs incentive arrangements and reacts according to the regulation and any demonstrated reduction in quality of care or access to services.

Physician contracts are also reviewed to assure that there are no “gag-clauses” in physician/provider contracts. Physicians must be free to recommend any medical treatments or procedures to the client irrespective of whether such are available through the MCO.

Monitoring of Access to Services in Managed Care

Under the regulations required by the Balanced Budget Act of 1997, the Department is required to assure that access to health services is not significantly different for members under the state plan for managed care as compared to members not enrolled in managed care.

- Members may choose any of the participating providers in the waiver area as his/her PCP/MCO.
- The same range and amount of services that are available under the usual Medicaid program are available for waiver enrollees.

- Distance and travel time to obtain services for members under the waiver has not substantially changed from that of the usual Medicaid program.

Availability of Providers

Statistics are required to be monitored each month on the number of persons enrolled in the Iowa Plan by county and the number of persons receiving services by county. Thus the penetration rate is determined by county to show access of providers in particular areas.

Prevention Activities

The Iowa Plan shall, as part of the quality assessment and performance improvement component of the Plan create annual prevention projects. The intention of this approach is to prevent further deterioration of function and to avoid the need for more intensive services in the future.

Preventive services - EPSDT

The Iowa Plan participating providers are required to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to all children identified as needing those services and will perform screening assessment when it is a requirement.

Quality Improvement: HEDIS-type Outcome Assessment

Outcome measures should reflect the quality of care provided within the Medicaid program to a variety of populations and over a period of time. Within this document the measures selected meet both of these specifications. Measures are also selected with other considerations in mind. First, there must be enough people within the managed care plans to provide adequate measure results. Additionally, the specified measures must have adequate data to calculate the appropriate ratios. As an example, many mental health measures are not useful because the Medicaid program “carves out” mental health benefits from the plans. Additional data sources are needed to calculate the measures and the plans do not bear responsibility for these outcomes. The Iowa Plan has additional reporting criteria reporting to the Department on a monthly basis. Those measures include:

1. Timeliness of Telephone Access- The number of seconds between the first ring and the line answer divided by the number of calls answered during the reporting month.
2. Wait times for initial appointments for emergency care, Urgent Non-Emergency Care, Persistent Symptoms, and Routine Services are established and monitored.
3. Availability of Evening and Weekend Appointments through survey of providers and retrospective review.
4. Admits for substance abuse residential services per 1000.
5. Residential substance abuse services average length of stay.
6. Mental health inpatient hospitalizations per 1000.
7. Average length of inpatient hospital stay.
8. Inpatient substance abuse residential care admits per 1000.
9. Partial hospitalization visits per 1000.
10. Outpatient visits per 1000.
11. Under and over utilization of services and causes of such.
12. Grievances per 1000.
13. Percent of grievances processed within 14 days.
14. Appeals per 1000.
15. Percent of appeals processed within 14 days.
16. Completion of provider network credentialing applications within 90 days.

Member Satisfaction With Services

Twice a year the Plan is required to conduct a member satisfaction survey. The questions are determined by the Advisory Committee based on national criteria measuring perceived access to services, quality of services, and perceived results of services in terms of financial and school or work success.

Our approach compares current survey information to prior surveys.

Quality Improvement: Consumer Survey Assessment

Survey questionnaires consist of approximately 30 items addressing behavioral health care access, use of services, and results of treatment as well as the quality of the delivery of services. A sample of claims is selected at random. Survey questionnaires are mailed to each enrollee (or his/her parent or guardian) in the sample. A reminder letter is sent out about twenty one days later to non-respondents.

Survey answers are reviewed after receipt and when individual issues are identified, they are addressed with corrective action.

Iowa Plan Performance Measures

The Department has undertaken the development of a series of performance indicators encompassing a full spectrum of issues that have been determined to be relevant to the operations of the Iowa Plan for Behavioral Health. These have been developed in conjunction with the Clinical Advisory Committee and the Iowa Plan Advisory Committee with input, therefore, of a number of consumers, advocates and providers of services. To assure that clients receive a full and comprehensive array of services offered in a timely and considered manner, the following performance measure have been adopted. These are reviewed on a quarterly basis by the Department and any areas that are determined to be less than optimal are discussed with the staff and management of the contractor. Within the organization of the Iowa Plan contractor, these performance measures, along with others, are reviewed on an ongoing basis. Where deficiencies are found, or if the performance is less than the stated levels, these must be fully addressed by the quality committee and any corrective action plan reported to the Department. Performance measures are reviewed by a committee of the Iowa Plan Advisory Committee prior to implementation and are periodically reviewed for achievement. The Iowa Plan contractor may be required to develop a corrective action plan at the discretion of the Department. The Iowa Plan contractor, an LSO within the state of Iowa is required to follow all of the managed care criteria regarding quality improvement, grievance process and access as any MCO

The following are the specific measures:

- Inpatient 30-day readmission by children and adults shall be 15% or less.
- The Contractor shall arrange or participate in 450 JTP conferences per contract period with the consumer participating in at least 97% of the JTP conferences.
- The average time between mental health hospitalizations shall not fall below 60 days for children and adults.
- The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 15% of all children admissions and 10% of all adult admissions.
- At least 6% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.
- 90% of persons discharged from mental health inpatient care will receive other treatment services within 7 days of discharge date.
- 60% of enrollees discharged from ASAM Levels III.5 and III.3 and receiving a follow-up substance abuse service within 14 days of discharge
- 90% of all discharge plans written for enrollees being released from a mental health inpatient hospitalization shall be implemented.
- A discharge plan shall be documented on the day of discharge for 90% of enrollees being discharged from the following mental health settings: inpatient, partial hospitalization, and day treatment. The discharge plan at a minimum includes the following first three items: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) as applicable; restrictions (if any) on activities and when they can return to work/school including the school setting.
- 95% of enrollees who received services in an emergency room and for whom inpatient care was requested but not authorized shall have a follow-up contact within 3 business days of the date the Contractor is notified of the ER service.
- At least 60% of enrollees discharged from 24-hour substance abuse services including PMIC (excluding Level III.1 – Halfway House) receive a follow-up substance abuse service within 30 days of discharge.
- A discharge plan shall be documented on the day of discharge for 90% of enrollees being discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting. The discharge plan at a minimum includes the following first two items: 1) the next appointment(s) and/or place of care, 2) emergency contact numbers, and 3) as applicable; medications, restrictions (if any) on activities and when they can return to work/school including the school setting.
- The percentage of enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 3% of all mental health inpatient discharges of children under the age of 18.
- Medicaid claims shall be paid or denied within the following time periods: 85% within 12 calendar days; 90% within 30 calendar days; 100% within 90 calendar days
- 95% of appeals will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal, other than in

instances which the enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.

- In the event of an extension, 95% of the time the Contractor will resolve the appeal within the additional 14 calendar day period, and, in the case of a DHS-approved extension, give the enrollee written notice of the reason for the decision to extend the timeframe.
- 95% of expedited appeals will be resolved as expeditiously as the enrollee's health condition requires and within 3 working days from the date the Contractor received the appeal, other than in instances which the enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.

In the event of an extension, 95% of the time the Contractor will resolve the appeal within 14 calendar days from the end of the 3 working day period, and, in the case of a DHS-approved extension, give the enrollee written notice of the reason for the decision to extend the timeframe.

- 95% of grievance will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 90 calendar days of the receipt of all required documentation.
- Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 60% within 30 days; 100% within 90 days.
- Revisions to the Provider Manual shall be distributed to all network providers at least 30 days prior to the effective date of the revisions.
Mailing dates of provider manual material shall be sent at least 30 calendar days prior to the effective date of material contained in the mailing. This measure applies to all information sent for all network providers.
- New enrollee information, including a list of network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name was provided to the Contractor. The standard shall be met for 95% of all enrollees, and in no case shall more than 15 working days elapse.